



DRAMA THERAPY IN THE TREATMENT OF COMBAT-RELATED POST-TRAUMATIC STRESS DISORDER

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Post-traumatic stress disorder (PTSD) was formally acknowledged in 1980 by the American Psychiatric Association as the result of the efforts of many professionals in collaboration with Vietnam veterans who were suffering from the disorder. Since 1980, PTSD has become a unifying concept for responses to stresses originating with a traumatic event, such as child abuse, rape, earthquakes, accidents, torture, war and hurricanes. The major symptoms of PTSD include (a) reexperiencing symptoms, such as flashbacks, intrusive memories and dissociative experiences, (b) avoidance symptoms, including numbing, isolation and avoidance of reminders of the traumatic event, and (c) hyperarousal symptoms, including sleep disturbance, anxiety, anger, impulsivity and startle responses (van der Kolk, 1987).

An essential aspect of PTSD is that the individuals, in order to protect themselves from pain, dissociate the self from the traumatic material through amnesia, splitting or isolation. The traumatized persons often feel alienated from “normal” people, who will never be able to understand what they experienced. PTSD patients become intolerant of others, reflecting a more fundamental intolerance of themselves as a result of the shame evoked by having participated in the horror. One cannot live with what happened, and therefore a piece of the self must be cut off forever and other people must be kept at bay. Because states of emotional arousal are apt to evoke the split-off self,

representations of emotion are curtailed. A state of alexithymia ensues (Krystal, 1979).

Current models of PTSD treatment include a variety of methods that attempt to access the split-off memories. Many of these approaches encourage the patient to reexperience the original affect: hypnosis attempts to release the pent-up affect through catharsis during a trance state (Crasileck & Hall, 1985); implosive therapy and flooding techniques attempt to desensitize the patient to the trauma while in a relaxed state (Lyons & Keane, 1989). Psychodramatic techniques in drama therapy are similar in function to these approaches. Psychodynamic psychotherapy has been used extensively, shifting between expressive and supportive phases based on the needs of the patient (Horowitz, 1976). Group therapy, particularly peer support and rap groups, has been a mainstay of trauma treatment due to its ability to help victims acknowledge that they are not alone and find acceptance again as human beings (Shatan, 1973). More recently, psychoeducational and cognitive-behavioral techniques have been employed, helping victims learn coping strategies to manage their anger, stress and isolation (Flannery, 1987).

The creative arts therapies have firmly established themselves in the treatment regimen for PTSD patients (Golub, 1985; Johnson, 1987; Malchiodi, 1990; Simonds, 1994). Because many traumatic memories are coded nonverbally in kinesthetic and visual forms,

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the nonverbal media of the creative arts therapies are able to facilitate access to these memories. The use of artwork and puppets to assess child abuse, for example, is now standard procedure (Wohl & Kaufman, 1985). Because the arts media allow for distancing from distressing affect, they also have been helpful in the working through process. The patient often experiences greater control over the emerging process, being able to titrate the intensity of affect by manipulating the art form (MacKay, Gold & Gold, 1987). Finally, because the arts media can involve performance or public display to an audience, they have been helpful to PTSD patients by providing avenues for community acceptance and re-integration (Johnson, 1987).

Combat-related PTSD

Previously described as war neurosis, shell shock, battle fatigue, soldier's heart and nostalgia, combat-related PTSD has affected millions of people. In a recent study, 30% of the 3.1 million Vietnam veterans were found to be still suffering from PTSD (Kulka et al., 1988). Combat-related PTSD presents unique challenges for effective treatment. First, although most sufferers of PTSD are victims, combat veterans are often both victims and perpetrators. Many soldiers who later develop PTSD have experienced traumas that they themselves have caused, such as killing innocent people. Second, unlike many single-event traumas, such as rape or building collapse, combat trauma typically occurs over many days or months. The culminating effects can therefore be severe. Third, the traumas of battle are legitimized acts of violence, authorized and celebrated by the nation. Therefore, combat traumas have both moral and immoral, legitimate and illegitimate, status, creating a profoundly confusing situation for the PTSD patient. For treating staff of combat-related PTSD, these confusing conditions provide significant challenges, as one's patient may in fact be suffering from the commission of unspeakable atrocities (Haley, 1974). Finally, treatment for Vietnam veterans is complicated by the length of time since the war, and many of their problems are chronic and only indirectly related to the original trauma.

Consequently, the problems of Vietnam veterans are not only contained in their traumatic memories; they also suffer from the effects of a sociopolitical process that framed their experiences simultaneously as hateful and murderous and as weak and inadequate. Thus, in addition to suffering from the traumas of

battle, they suffer what are called secondary traumas of return (as a rape victim might experience being blamed for her rape) (Catherall, 1989). Instead of receiving appreciation and support in returning from the horrors of war, these men and women received ridicule and denigration, leading them into longstanding maladaptive patterns of substance abuse, violence and dependency. Their psychological state is now one of intense alienation, constriction and negative self-image; their inner worlds are highly demoralized and compartmentalized. Now in their late forties, many with children from earlier marriages, they face both the responsibilities of middle age and the reality that their inner resources have been severely depleted.

The Drama Therapy Program

The drama therapy program is part of an integrated treatment program for Vietnam veterans in a Veterans Affairs Medical Center. This is a 27-bed unit that admits Vietnam veterans in cohorts of 15 for a four-month course of treatment. They receive intensive individual, group, family and milieu therapy, a psycho-educational program and many other rehabilitative treatments. The creative arts therapies, including art, music, poetry and drama therapy, are integral parts of the treatment (Blake & Bishop, 1994; Dintino & Johnson, 1996; Feldman, Johnson & Ollayos, 1994; James & Johnson, 1996). Patients are required to attend these groups, which include a one-hour per week drama therapy process group throughout the program, a video/drama therapy group and a rehearsal group leading to the performance of an original play about coming home from Vietnam. Many of the patients are also seen in individual drama therapy by staff or drama therapy interns.

The drama therapy program focuses on (a) process (i.e., playing in an imaginative world of drama) (b) practice (learning effective coping behaviors through role-playing) and (c) performance (preparing autobiographical theatre for audiences). Each patient has the opportunity to try out these modes of drama therapy during the program.

Developmental Transformations

The basic approach of our drama therapy work is Developmental Transformations, through which patients are familiarized with an improvisational, playful environment (Dintino & Johnson, 1996; James & Johnson, 1996; Johnson, 1982, 1986, 1991, 1992;

Johnson, Forrester, Dintino, James & Schnee, 1996). In this approach, the group sessions begin with unison movement and sound activities in a circle, then move through defining stages where images are developed, into personifications of characters and roles, leading to structured and finally unstructured role plays (Johnson, 1986). The therapist does not lead the group through a series of organized exercises, but rather makes many minor adjustments in the action according to developmental principles. Thus, the therapist moves from leader-directed to group-determined structures, from simple to complex activities, from actions of low to high interpersonal demand and from relatively impersonal to more affectively-laden content (Johnson, 1982). The therapist's job is to preserve the *playspace*, that is, the sense that the group exists within an imaginary, pretend environment in which feelings can be played out (Johnson, 1991). The playspace is the empty stage where the inner world of images and personifications can be encountered. As anxieties related to internal conflicts emerge, the group experiences impasses that the therapist can use to understand the ongoing process. The therapist attempts to maintain the sense of continuity and playfulness in the session, called *flow*, by allowing retreats into less developmentally challenging structures.

The major focus of Developmental Transformations is not the specific re-living or problem-solving of life experiences, nor achieving catharsis, but rather embracing an attitude of acceptance and tolerance of the multifaceted aspects of the self, good and bad, profound and superficial. The goal becomes to expand the freedom that the individual has in moving from one level of experience to another, rather than the ability to work out one particular conflict.

This sense of play and freedom within the inner world is noticeably lacking in patients with PTSD and even more so among combat veterans, most of whom have never experienced drama before. These "tough" men enter the drama therapy room as if it were an alien world. Their PTSD makes this experience even more threatening. First, drama therapy, by evoking internal states, threatens to provoke a re-experiencing of the trauma. Patients are often extremely fearful that a supposedly playful action in the warm-up will evoke a memory of a dead buddy or a war incident. Second, the fact that the drama therapy session may involve intense emotion threatens to overwhelm their avoidant defenses, and even the most benign image or sound in the session may lead to resistance, numbing or desires to leave the room. Finally, these patients' hyper-

arousal symptoms are easily provoked by the energy of a drama therapy session and they fear losing control, as if simple actions will turn to violence or breathing will become shouting. For example, one patient came late for each session. He was extremely tense and complained of pains in his legs. He attempted to divert the sessions into discussions about the purpose of the group. He finally loudly warned the therapist that if he opened up and let out what is inside he would lose control and hurt people in the group. He asked to leave. The therapist looked him in the eye and said, "No." The group was a required part of the treatment. The therapist was aware that this patient had killed people in Vietnam and had been imprisoned for assault since returning. He also knew that the patient was hurting deeply inside and was hoping that the therapist would not back down.

Thus, the drama therapy session is a profoundly threatening environment for Vietnam veterans. Developmental Transformations offers them an opportunity to experience a flow or continuity in their personal experience not dissociation; tolerance rather than suppression of emotion and freedom to play with rather than be constricted by their memories. The capacity to open oneself up again to identifications and to share one's inner world with other people is the goal of our work.

This therapeutic process evolves through three phases. First, the patients' sense of *rage* that they have been betrayed must be lived through. This attitude soon transforms into a sense of profound *shame* and self-disgust that one was soiled by the traumatic event and deserves God's wrath. To pass through this phase, patients must experience their shame in the presence of fellow sufferers. Finally, the capacity to accept what has happened as a near-random event, yet tolerating the consequences and lifelong burden, brings the patients into an *empathic* stance regarding other people, allowing them to both take from and give to others. We will now describe the three phases of drama therapy work with Vietnam combat veterans with PTSD, illustrated by two extended case examples.

Rage Phase

The symbolic imagery in the rage phase is predominantly characterized by primitive and violent affect. The quality of the emotion is intense and undifferentiated, leaving the patients vulnerable to emotional flooding. The actions initiated during this stage

tend to be brutal and destructive without regard for consequences. The group usually has little ability to structure their experiences without the support of the therapist. The challenge for the therapist is to provide strong external support and dramatic structures that contain the emerging affect so that the patients are not overwhelmed by these intense emotions.

For example, one session at the beginning of drama therapy was dominated by rage. Movement qualities were punching, slashing, pushing, crushing and wringing. Sounds that were added to these movements were grunts, cries, howls, screams and growls. Strong primitive rhythm patterns spontaneously developed and the group repeated movements instead of transforming them. Eventually Fred transformed one movement into a symbolic gesture of chopping wood, which was transformed by another patient into driving railroad spikes and then breaking large rocks with a sledgehammer. Traumatic material emerged as Alan began cutting through the elephant grass of Vietnam and Jack attacked an enemy soldier with karate. The enemy was crushed underfoot and the image transformed into dog "shit" that each person had to clean off their shoes. The group delighted in playing with this image, showing much humor and energy. The shit was spontaneously transformed into other disgusting substances. At one point Fred took the "slime" and threw it onto another patient. The group greatly enjoyed the interaction as they soiled each other, transforming from a "slime" fight to a "food fight" and finally a "soiled underwear barrage" against opposing armies. In this session the group was able to contain their anger within a playful structure.

The rage phase of a group's development is often characterized by high levels of energy and symbolic material involving anal imagery and attacks on external authorities: their doctor, family, government or the therapist. The therapist willingly plays out these authorities. For example, in one session the therapist stepped into the center of the circle and invited each member to destroy the therapist in any way they chose. Mark tossed a grenade at the therapist, Walter blasted him with a machine gun, and Mark put a pistol to the therapist's head. The therapist was blown up, disemboweled with a bayonet and strangled with a wire, much to the members' delight. Spontaneously, the group divided into two armies, created pantomimed war weapons and tried to destroy the other side. The debris from the resulting conflagration was gathered into the center of the room. Group members suggested that this dust be buried or burned up. The

therapist suggested molding the dust into clay and quickly a clay man was formed in the center of the circle. Each patient then spoke to the clay man, who became politicians and authority figures, such as police and doctors with whom they were enraged.

Jack: (talking to Nixon) I'd like to put you out on the front line, see how you like it.

Joe: (talking to the VA. compensation officer) You work for me; I'm your boss; go ahead and call security; I'll take them all on.

With great glee the group pulled these authority figures apart limb from limb and tossed their mangled corpses into a pile. These enactments became more specific as the session progressed. The therapist entered the circle to play one of the roles suggested by the patients.

Therapist: (playing a boss) Sit down Jack. I don't like what I have been hearing . . . You have been late this week, and you have lost your temper many times . . . the other men are complaining.

Jack: (in a rage) Who the fuck do you think you are? You can't talk to me like that, you young punk, you're nothing. You come in here and talk to me like you're so high and mighty. Fuck you; I don't need this job. Go ahead and fire me; I don't give a shit! (At this point the patient pretended to throw the therapist/boss out the window.)

Each patient was allowed to act out an ending that gratified their desire for revenge on authority. Typically, these scenes move from more distant authorities (e.g., Nixon, employers) toward more personal figures, such as therapists, ex-wives or parents. The rage expressed by some Vietnam combat veterans is particularly intense and primitive when it is related to unmet dependency needs from childhood. The object relations that emerge in the session frequently give a sad picture of the dysfunctional family systems that patients experienced before suffering trauma in Vietnam. Abusive and abandoning parenting left these patients more vulnerable to the effects of war. Indeed, many of these men joined the military as a way of finding a father, only to be betrayed by the military authority and then to be further rejected and abandoned on their return to the United States.

Steve: (screaming at his father) You were never there for me! Where were you? You bastard!

Therapist: (playing the father) Don't talk to me like that! I am your father, shut up!

Steve: (in a rage) A father! When have you ever been a father? You have never been there! You are nothing! You bastard!

Another patient spoke to his father.

Mike: Where did you go? You left without even saying goodbye! Do you know how much that hurt us, how much we needed you? I don't think that I can ever forgive you!

Though the affects expressed in this session were disturbing, the flow of the session was strong, indicating that the patients felt sufficiently safe and that the rage was contained within the playspace. The patients seemed assured that they could express their affect without re-experiencing the trauma.

Throughout this phase, the therapist demonstrates the interconnections among the sources and targets of this rage through transformations of these scenes from childhood, combat and current familial scenarios. The patients hopefully begin to understand the pathways of their rage, gaining more control over their anger and not directing the destructive effects of war onto their families.

Example One: Babies

This session is an example of a group moving from the Rage Phase of development to the Shame Phase.

The pre-session mood was somewhat subdued and tense because one of the group members, Mark, was attending the session for the first time. Mark had remained aloof from the group, who were mistrustful of him because they knew that he had worked as a policeman. He had successfully avoided two previous drama therapy sessions.

The therapist began the session by closing and locking the door to avoid intrusions into the session space. He then asked the group to stand in a circle and led them in a series of warm-up movements, which included punching, shaking, wringing, pushing and gliding movements with different sounds to accompany the movements. The therapist noticed that the group seemed to be invested in direct and violent movements, suggesting that the underlying affect might be interpersonal anger.

The warm-up sounds and movements were then transformed by the therapist into a sound and movement toss, which stimulated the flow of associations among the group. Each member began to offer variations. Movements included punches, kicks, a grinding movement with the hands and wringing movements, such as wringing out a wet towel or breaking a cat's neck. The sounds accompanying these movements were grunts, growls and percussive "huh" sounds. These forceful sounds and movements were full of angry affect. Bob became uncomfortable as the violent affect became more pronounced and he transformed the movements into gliding slow arm gestures with a "shhh" sound. The group seemed relieved by this and the energy and flow increased. However, the group returned to the more violent and direct movements a short time later and this time Bob participated more comfortably.

The therapist next directed the group to turn to each other, increasing slightly the interpersonal demand. The group responded with more flow, indicating to the therapist that they were comfortable with this progression. These movements spontaneously transformed into symbolic gestures of raised fists and gestures like "giving the bird" to each other. The image of throwing some strange substance on each other began to emerge, joined by sounds of disgust as the group members tried to avoid the "stuff," which Richard defined as shit. Bob transformed the image into water that the group splashed on each other. The therapist understood this as Bob's attempt to distance the group from the shit image.

The therapist (in an effort to support the group defense) provided the dramatic structure of the "wash line." An assembly line formed down which each group member traveled to be laundered. This structure seemed to reduce the anxiety that had been visible a moment before. The group enjoyed spraying each other with water, and comments about how dirty this or that group member was were made with great humor. The group then began to judge each member as to how much shit they had been covered with.

The dramatic structure then further transformed into a "shit shakedown." Each group member was physically brought into the center of the circle by the other members and the shit was shook out of them onto the floor. The therapist was the last to have a "shakedown," which the group enjoyed greatly.

One group member questioned whether the therapist had ever seen so much shit and wondered if he could take it. The therapist entered the center of the

circle and invited the group to load him up with their shit. He was piled high and was playfully crushed under its weight. He sensed the group's fear that he would be overwhelmed by their feelings of anger or destroyed by what was inside of them. The playful acting out of fear helped reassure the group that he was aware of this concern. The group flow was high at this time, providing evidence that the anxiety was contained.

Then, a striking transformation occurred. Bob initiated clapping his hands quickly. The clapping intensified and group members knelt down to slap the floor. At this point the group quickly rolled over on their backs and became babies screaming, crying and waving their arms in the air. They were completely caught up in the play. The therapist allowed this dramatic structure to continue and directed the energy of the babies toward each other. The personifications transformed from babies screaming for mother to small children calling for their dads and moms. The group became school-age children on a playground. The group added words to the sound and movement. The phrase, "my father could beat your father," was repeated over and over by the members of the group to each other. A schoolyard competition developed with each child yelling louder than the others. The kids then began to make fun of differences in the group. Each kid made fun of something about the others. The group particularly enjoyed making fun of the therapist who acted out his hurt feelings and went from person to person in search of a friend, playing out a needy, dependent boy. As this role developed, the therapist began to beg for "meds" (in this way linking the dependent figure with patients' neediness). This *action interpretation* (Johnson, 1992) was immediately recognized by the group and they laughed when the connection was made. Mark stood up at this point and became an adult.

The therapist then entered a role play with Mark in an attempt to further define emerging relationships. The therapist/child asked if Mark was his daddy. Mark rejected this question rather brutally. The rest of the group then became fathers and the therapist/child went from father to father asking if they were his daddy. The group repeatedly rejected the therapist/child. William became uncomfortable with the rejection of the needy child and held the therapist around the shoulders, protecting him from the other group members.

William then transformed the scene into an attack by Vietcong on two friends in a bunker. The therapist

asked how they could get out of this situation. William suggested that they make a run for it, which they did and were killed by the Vietcong, played by other group members. The therapist then structured the action in which each man in the group was wounded and brought to the hospital by the other group members. Group members commented that they were trying to save their lost youth, Vietnam buddies, dead family members and even "lost" group members like Mark.

The level of anxiety was high at this point and an impasse occurred as the energy flow decreased dramatically. In an attempt to maintain the flow of the session, the therapist transformed the action into a television show called "Save your family." This *bracketing* technique (Johnson, 1992) distanced the group from the powerful affect that was emerging and threatening to overwhelm the participants, thus allowing continued exploration. The therapist became the show's host and Mark became the father. Each group member played a brother between the ages of 11 to 13 with one patient William, the oldest brother of 18. Bob became the baby of the family. Within the dramatic structure of the television talk show, the therapist interviewed the children about their feelings toward their parents. At this point in the session the angry and needy affect was intense, evidenced by playful yelling among family members. Indeed, the therapist had a hard time filling his role of the talk show host and maintaining the format of the show.

William: (angrily at Mark, playing his father)
You were never there! I had to take over everything!

Brian: (to the therapist) He beat me!

Therapist/host: He beat you, Brian?

Brian: (choking up) Yes! He hit me in the face with a strap!

Mark/father: You kids are always after me for something! You always want something from me! I work my ass off all day!

Bob: You and mom are always yelling! Stop it! I can't stand it!

Therapist/host: Mr. and Mrs. Smith, you will have to remain quiet while I talk to the children!

However, the group broke into a melee of vociferous accusation, though they clearly enjoyed expressing their angry feelings, evidenced by a high level of flow.

To allow the group to take even more distance from this scene, the therapist facilitated a transformation by turning the children into famous family therapists discussing a difficult case. He hoped that they would be able to explore the reasons for the parents' behavior and look at the situation in a more balanced way. The group then discussed the etiology of this family system.

Bob: It is obvious that the father has been abused himself, in what way we don't know.

Brian: Yes, I agree, Doctor Schwartz! Probably some sexual abuse.

William: The mother is obviously troubled as well!

The therapist/host thanked his guests, families and television viewers for tuning into the show. He then told them to stay tuned for next week's show and signed off. The group formed a circle for the final phase of the session. They placed all of the images of the session into the Magic Box and put them away. This structure allows the group to leave the playspace and review the session (Johnson, 1986). In the discussion at the end of the group, each member expressed how glad they were that Mark had participated. Mark said he felt good to be a member. The mood was one of comfort and friendly tolerance. Group members expressed how much more relaxed they felt, even though they had expressed so much anger.

Discussion. In previous sessions the members seemed more concerned with their problematic relationships with authority, especially the therapist as a transference target for their rage. In this session they began to show an interest in their relationships with each other, particularly around issues of trust, intimacy and openness. This signaled the developmental advance in the life of the group, allowing isolated members to make progress. For example, Mark's distance from the group seemed linked to unmet dependency needs from his childhood. As the abusive father, Mark found a way to integrate himself into the group. The therapist facilitated this growth by providing relevant dramatic structures to contain their unintegrated, primitive feelings. This containing function of the therapist is essential during the rage phase. Evoked countertransference in the therapist ranged from fear of members' violence to protective feelings

toward them. He used these feelings to guide his choice of interventions within the playspace.

Shame Phase

The second stage of group development is characterized by the expression of vulnerability through themes of impotence, loneliness, regret, guilt, fear and doubt. Issues of intimacy rather than authority are foremost in the drama therapy session. Shameful or embarrassing secrets are revealed in the context of the playful rendering of rejection and ridicule. Fragile aspects of the self that the patients are desperately trying to protect from the trauma are represented as small innocent figures surrounded by powerful monsters or evil forces. If this shameful material is tolerated by the therapist and the group, patients will be able to move toward forgiveness. The therapist's role is to be nurturing and accepting, modeling respect and tolerance for their unique experiences. Haltingly, the group will begin to grieve the many losses that they have suffered.

Physical movements within the shame phase are more fluid than the percussive movements of the rage phase and often have swinging, rocking or gliding qualities. Sounds that develop from these movements tend to be humming, chanting, howling or distant calls, suggesting, for example, a lost traveler or a lone wolf in the distant forest. Though symbolic gestures may be similar to those in the rage phase (e.g., giving the finger or smacking a small child), in the shame phase the patients identify with the victim (e.g., the abused child) as opposed to the perpetrator. Masochistic images, such as whips or spankings, are also not uncommon in the shame phase.

In one group, personifications of puppies, kittens and babies emerged. Although some patients wanted to protect these little creatures, others could not tolerate these vulnerable beings and destroyed them. Babies were dashed to the floor or destroyed in more brutal ways, reflecting their rejection of the vulnerable parts of their self-images. For some patients, the emergence of the child role threatens to reveal their own inner child, therefore the role must be rejected. Others are better able to tolerate personifications of vulnerability and will save, protect and nurture the child in the role playing.

In another group, the image of a door emerged, hot from a fire on the other side. The group determined that they were firemen in a burning building rescuing

a child who was trapped inside. The child was saved, and then adopted, and given a name and a home. This symbolic child came to represent their hopes for treatment and a better future.

During the shame phase, the open acknowledgment of loss and the identification with the victim role encourage group members to direct their attention to each others' internal experiences. One group transformed a physical movement into a large, heavy stone that was difficult to pass around the circle. The play transformed into a contest to see who could carry the biggest burden. Each patient took a turn in the center of the circle and was loaded up with weight by the group. This structure then transformed into a juggling act, with each patient showing off his skill by juggling his burden as the group threw him images to be juggled, such as weapons, human body parts, guilt, shame and fear. The juggling then transformed into a large cauldron into which each person's burden was thrown, melted down and stirred. George stepped into the pot and began crushing the "grapes of wrath," making it into "the wine of despair." The group decided that whoever drank this wine would know how a Vietnam vet really felt inside. Each patient and the therapist drank the potion and revealed their insights. Sadness prevailed in the session as each member quietly admitted their loneliness and regret. The fear that nobody understood them, that they are like Cain, marked by the guilt of the survivor and forever banished, was evident.

In another group, a very powerful symbol emerged in a session during the third week. The session began in the rage mode but quickly moved into the shame phase. The group was being "shit" on from above, which the therapist initially understood as the group's experience of authority. However, as personifications were pulled down from above, the therapist realized that the group was referring to personifications within the group, particularly members who had not shown up on time. Each person who bogged down the group was captured, made to answer for their behavior and then put into the group's "sewer" (a structure brought back from a previous session). Obviously, the group experience was being valued and protected. The iron lid of the sewer was then removed and everyone's negative attitudes were disposed of into the pit. This mess was then zapped and a personification of a huge fat, ugly, critical man emerged. This Being leapt out of the sewer and attacked the group, who captured him. Each member then played out a scene with the "Critical Man."

Therapist: Who are you?

Critical Man: (played by patient) I am your inner voice.

Group: ooohhhh, nnooo!!!!

Critical Man: You will never amount to anything; you will always be drug addicts and junkies; you will never have a real woman in your life; you will always be dirt; you are dead, nobody wants you in the world; you should be dead; your future is shit!

Therapist: No, I won't let you say that to these patients; there is hope; there is love for them here; we do want them, you bastard; I won't let you destroy the group with your bullshit; I defy you!

Group: (cheering) Yes, tell him!

At this point the Critical Man attacked the group again, swallowing each member. Each of the players was rescued, but the Critical Man persisted by trying to suck the group into the sewer. Eventually he was sealed in the sewer as the session came to a close. In the group discussion following this session, members energetically acknowledged their own internal critical voice that prevented them from joining the world. Our experience has been that this toleration of shameful affect in the session precedes the sharing of traumatic memories, which serve as pivotal moments in the therapeutic process.

A group that was having difficulties accessing their painful memories created the personification of a "memory dentist" who extracted painful memories. The therapist played the character of the dentist as each patient sat in the chair. He reached into the heart of the patient and with much struggle pulled out a difficult memory and put it into the "memory projector." The patient then described for the group the painful memory as it played on the screen.

Rich: I see the jungle; choppers are coming in; we are getting much ground fire; the choppers can't land. We are taking many hits. Doug is hit. I am holding him in my arms; he is dying . . . (patient is very tearful) . . . I can't help him. (The therapist at this point encourages Rich to speak directly to the dying soldier.) I love you; I'll get you home; I promise you.

The patient experienced some relief from this scene. He had been a captain in Vietnam and had lost many men he felt he should have protected. Another patient

then expressed a memory that revealed his own difficulties with forgiveness.

Henry: (to his dead grandfather, played by the therapist) I miss you; I wonder if you know what I have done?

Therapist/grandfather: Yes, I have been up here in heaven watching over you. You have had a hard time.

Henry: I don't know if I can forgive myself; can you forgive me?

Therapist/grandfather: Can you forgive yourself? (the group brings Henry over to the therapist) I love you grandson; I will always love you. (The therapist takes Henry in his arms for several seconds.)

The patient was very grateful for this contact from the therapist and their therapeutic bond was strengthened. During the shame phase, it is very important that the therapist unabashedly model positive, affirming support for the patients and not merely interpret their need for love. Such open expression of support will emerge among the group members in the empathy phase.

Empathy Phase

The third phase of treatment is characterized by the patients' acceptance of their losses and recognition of their fundamental humanity as they strive toward forgiveness and renewed mutuality. This phase is characterized by greater openness of members to each other's thoughts, allowing previously discrepant or suppressed feelings to emerge. Feminine, nurturing and receptive qualities are portrayed with equal relish as aggressive ones. Images and scenes are more differentiated and differences among members are acknowledged without ridicule. The therapist is no longer required to provide a highly dominant, structuring presence and, instead, becomes the group's play object to be projected upon and transformed in more flexible ways.

In one group, physical movements and sounds were dance-like and free. Leaps and turns were performed with a light quality. From the beginning of the session, the levels of concentration, play and flow were very high. Personifications developed quickly, transforming from impulses initiated by the group to images of being "caught" to high school kids smoking in the bathroom. This scene then quickly trans-

formed into prom night, patients and therapist emerging as the rock band hired to entertain at the event. Spontaneously the band played a song called: "I'm on the outside looking in." As the principal was denouncing the evil of rock and roll, the scene transformed into a faith healing service. The patient who was the healer performed the "laying on hands" with members of the congregation. As each member was healed, the congregation clapped hands and chanted "amen" with great enthusiasm. One patient turned out to be particularly sinful and required the special attention of the faith healer. He was placed in a chair in the center of the room and the congregation danced in a circle around him. The healer cried, "Brothers, we are here to be healed!" The group responded, "Yes!" Healer: "Even though we done that rock and roll!" Group: "Yes, we can save his soul!" Everyone was aware that "rock and roll" meant indiscriminate killing in Vietnam.

The therapist then facilitated a transformation into a "Rockaholics Anonymous" meeting. Each of the group members stood before the group and confessed their "disease" to the group.

Jim: My name is Jim and I play rock and roll.
Last night I got out my guitar and played.

Group: NOOOOOOOO!

Jim: Yes, then I called my brother and he brought me here.

Group: (applauding) Yeah!!!!

As each member of the group stood up and confessed, the other members opened their arms and hugged him, celebrating their success in saving a brother. The meeting finally came to a close with an improvised blues song. There was a quiet and deep sense of acceptance of themselves and of each other. The group had been able to tolerate intimacy and find support and forgiveness. Their ability to play with the idea of having a chronic mental illness was an indication that they were better able to live with the burden they must carry together.

Example Two: The Shame Man

This session is an example of a group positioned in the shame phase of development and progressing into the empathy phase. Robert entered the session room five minutes early complaining of physical pain in his legs. He angrily warned the therapist that he would be unable to participate. The therapist remained silent

and listened, suspecting that Robert had come early to negotiate being excused. The therapist empathized with the pain, but did not excuse Robert from the session.

The therapist began the session by asking everyone to stand up and form a circle. He then led the group in a series of warm-up movements that included gliding, punching, flicking, pushing, pulling and slashing. Everyone followed these movements with full energy except Robert, who performed them in a halfhearted and angry manner. The therapist's attempts to encourage Robert to participate were rejected.

A sound toss structure developed in which group members made light, quick, flicking movements alternating with more violent, direct movements and sounds. The therapist wondered whether the group was holding back painful feelings through repetition of the lighter movements. An image of a "burden" emerged. The weight shifted from light to heavy as the group members passed this burden around the circle. The therapist asked each group member to show how much of a burden he carried as the weight was passed to him. Each member playfully fell to the floor under the object's weight. The therapist then transformed the burden into one that could be carried by the entire group. As the group reached into the center to pick up the burden, Robert refused to continue and left the session room. The therapist had unsuccessfully encouraged him to remain in the room. The energy and flow in the room dropped dramatically as the group reached an impasse. The therapist noted that Robert's exit was unfortunate. The therapist felt that the group might be able to explore their feelings about this exit through movement and sound. He said, "Looks like we have dropped the ball!" and led the group in reaching for a ball in the center. This action transformed into movements full of angry affect, such as punches and throwing movements. The group enthusiastically threw out the undefined, unwanted "weight" and the flow of the group was again established. The therapist wondered whether the group wanted to throw out Robert or perhaps the painful feelings that Robert symbolized.

Unfortunately, at this precise moment a nursing staff member entered the session space and requested Henry for a medical appointment. This was an unusual event and seriously disturbed the flow of the session again. After this intrusion was negotiated and the patient was allowed to leave, the therapist attempted to begin again. He was very angry at the intrusion and knew the group could see his reaction.

Though the group seemed extremely self-conscious, they seemed ready to resume the play. The therapist offered the dramatic structure of the Magic Box, which he explained contained all that had been lost and is precious, a theme he believed was present in the group. Images that emerged out of the box were a baby, a small bird, lost youth, confidence, love and strength. The therapist chose to define the baby image further. The baby was passed around the room and each group member was asked to speak to the child.

Mark: (to the baby) Why don't you grow up!

William: You cry baby!

Brian: You have shit in your pants!

The group unsympathetically passed the baby around, making disgusted noises as they smelled the soiled child. However, when William offered to change the baby's diaper, the energy dropped radically, indicating to the therapist that the group might be avoiding shameful feelings.

Mark transformed out of this impasse by changing the baby into a basketball, and the ensuing game increased the energy in the group. The therapist attempted to preserve the disclaimed imagery by taking the basketball and throwing it into the center of the circle with disgust. The group followed by throwing away (yet undefined) stuff into an iron cauldron, then stirring it in a dramatic fashion. William spontaneously announced that these were unwanted feelings. Brian then began to chant: "Boil, boil, toil and trouble," and the group danced in a circle throwing unwanted feelings into the cauldron, including hate, anger, fear, shame, guilt, sadness and regret.

The therapist characterized the group as a covenant of PTSD warlocks who were meeting at midnight to deal with the painful feelings that they could not deal with. The group's energy increased and a sense of mystery pervaded the playspace. The therapist warned the group that the soup in the cauldron could destroy them if they did not proceed with care and remain in the magic circle of safety. He intended to indicate he was aware that this was difficult for them and that he would proceed carefully.

The flow at this point in the session was very high and the group seemed immersed in the imaginative world evoked by these images, resulting in a powerful sense of mystery, fear and excitement. The stirring of the soup in the cauldron gradually became more difficult to perform. The therapist asked the group to name the emotion that was so thick and William

named it "shame." The glop was taken out of the cauldron and placed on the floor with a powerful sound of "splat!" This glop was now a thick claylike substance.

The covenant leader/therapist suggested that the group form the blob into a human being. He offered this structure in order to transform the shame affect from impulse and gesture into more defined personifications. The form of a man began to develop as each member described one aspect of the being. William said that the Being was crying and had a fearful face. Mark said he had shabby clothes and was covered with wounds or knots of wood. Brian described him as being afraid of the group.

The therapist then assigned Brian to be the voice of the Being and to answer group members' questions. The energy around this personification was very intense; there was a very sad feeling in the playspace. The group had apparently created someone who was very hurt and ashamed. Group members spoke in hushed tones and were very gentle with the "Being."

Therapist/leader: You are ashamed; what have you done?

Brian/being: I have done bad things!

Therapist/leader: Can you tell us?

Brian/being: No! I have done things that cannot be spoken!

William: You are not alone. We all have done bad things! You can tell us!

Mark was now weeping openly, tears streaming down his cheeks.

Therapist/leader: Why are you weeping? Tell us, we are here to help you!

Mark/being: I have hurt people, I have beat people!

Mark's voice choked with tears, weeping with deep sobs that shook his body. Others in the group now began to weep and the drama therapist also felt tears welling up in his eyes.

William: We have killed! We have all killed! (to Being) You are not alone!

William then put his arms around Mark, both men weeping. Brian hesitated, struggling with his fear of showing emotion in the presence of his fellow veterans. After a moment he moved to join the group

which had formed a silent circle. The men wept with heavy deep sobs, after which a respectful silence filled the room. The therapist placed Mark in the center of the circle and then, in a formal manner, spoke Mark's name and asked him to turn and look at the group.

Therapist/leader: Will you, Mark, let us help carry your pain?

Mark: Yes.

Therapist/leader: Then give us some of the burden (a reference to the earlier image in the session). Hand your burden to us!

Mark then turned to each one in the group and handed over his burden. Each group member in turn accepted the weight and hugged him. The group performed this ritual in a profound manner, tears mixing with laughter as the pain was shared by more group members. After the ritual was completed, the therapist asked the group to put the images and emotions that had emerged back into the Magic Box. Then the Magic Box was placed back in the imaginary storage space in the ceiling and secured. The group then sat down in the outer circle of chairs.

The mood of the group was relaxed, thoughtful and sad. The group seemed drained, but relieved. They expressed regret that two of their members were not there for the whole session. William wondered whether the group would have cried as it did if Robert had stayed, recognizing that Robert had played an important role in their group. William asked the therapist what he should do now with these feelings. The therapist suggested that they write in their journals and discuss them with other staff and each other. Members then briefly discussed how they could further integrate their rediscovered emotions into their lives.

Discussion. This drama therapy group explored the shamed aspects of the self, gave them a voice and allowed the feelings of vulnerability associated with this image to be expressed. The sense of loss that was stimulated by the two exits from the session put the group in touch with other losses: the loss of youth, innocence and ability to love. The group felt ashamed of what they had done in war and in their adult lives. The grief over their losses came out in full force during this session, though the emotions were safely contained within the dramatic structures. The intrusions into the playspace, though unfortunate, may have intensified the group's awareness of these issues. The therapist felt both profound pity and compassion for

these men. This group began in the shame phase, but advanced to the empathy phase by transforming the shame play into enactments of mutual support and shared grieving.

Conclusion

Underneath the defensiveness, the anger and the entitlement of the Vietnam veteran with PTSD is a person filled with grief and shame. Those of us who have witnessed the melting of crusty and intimidating veterans know too well the depths of their grief, the extent of their confusion and the reason for their avoidant defenses. Drama therapy using Developmental Transformations encourages exploration of feelings and relationships within a playspace that models tolerance. The journey through rage and shame to empathy is facilitated by the group members' trust in the leader/guide, a person who is willing to encounter the depths of their suffering. The dramatic playspace serves as the physicalized, yet imaginative, arena for this encounter among victim, therapist and the traumatic memory.

Developmental Transformations initially engages the veterans in unison sound and movement, out of which, remarkably, primordial images and feelings emerge that the therapist helps to structure within the aesthetic form of drama and play. Trusting the veterans' shifting needs for confrontation with their demons or retreat to safer waters, the therapist fully commits him or her self to follow the course of their therapeutic journey, whether it lead to laughter or grief. When successful, the playspace achieves a containing power that allows the veterans' inner world, with all its complexities and burdens, to be held at last.

Yet drama therapy is no cure for Vietnam, no repayment for the lack of a welcome home. Drama therapy cannot eradicate the memory of their dead buddies. The aim of treatment for veterans with the chronic form of PTSD is to minimize the extent to which the illness permeates and interferes with their entire existence. PTSD does not have to restrict their relationships with their families and friends, does not have to prevent them from working or contributing to society and does not have to destroy their self-esteem. Reclaiming those parts of the self that remain strong, that can still function, while tolerating the memories and grief of the past, is what drama therapy can help the veteran to achieve.

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